

Facility Name & ID Number CLARK MANOR CONV CENTER

0038596 Report Period Beginning: 01/01/02 Ending: 12/31/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds NONE

1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period
1	<u>273</u>	Skilled (SNF)	<u>273</u>	<u>99,645</u>
2		Skilled Pediatric (SNF/PED)		
3		Intermediate (ICF)		
4		Intermediate/DD		
5		Sheltered Care (SC)		
6		ICF/DD 16 or Less		
7	<u>273</u>	TOTALS	<u>273</u>	<u>99,645</u>

B. Census-For the entire report period.

1	2	3	4	5	
Level of Care	Patient Days by Level of Care and Primary Source of Payment				
	Public Aid Recipient	Private Pay	Other	Total	
8 SNF	<u>21,597</u>		<u>2,389</u>	<u>23,986</u>	8
9 SNF/PED					9
10 ICF	<u>64,658</u>	<u>621</u>	<u>34</u>	<u>65,313</u>	10
11 ICF/DD					11
12 SC					12
13 DD 16 OR LESS					13
14 TOTALS	<u>86,255</u>	<u>621</u>	<u>2,423</u>	<u>89,299</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.62%

SEE ACCOUNTANTS' COMPILATION REPORT

D. How many bed-hold days during this year were paid by Public Aid? 273 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy) NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒

I. On what date did you start providing long term care at this location?
Date started 11/1/77

J. Was the facility purchased or leased after January 1, 1978?
YES ☐ Date NO ☒

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 33 and days of care provided 2,389

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 12/31/02 Fiscal Year: 12/31/02

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number CLARK MANOR CONV CENTER # 0038596 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification	Reclassified Total	Adjust- ments	Adjusted Total	FOR OHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	A. General Services	1	2	3	4	5	6	7	8		
1	Dietary	309,053	29,043	18,868	356,964		356,964		356,964		1
2	Food Purchase		455,610		455,610	(88,359)	367,251	(31)	367,219		2
3	Housekeeping	252,717	64,311		317,028		317,028		317,028		3
4	Laundry	110,484	16,961		127,445		127,445		127,445		4
5	Heat and Other Utilities			197,875	197,875		197,875	(10,779)	187,096		5
6	Maintenance	29,936	24,973	119,317	174,226		174,226	(54,040)	120,186		6
7	Other (specify):*										7
8	TOTAL General Services	702,190	590,898	336,060	1,629,148	(88,359)	1,540,789	(64,850)	1,475,938		8
	B. Health Care and Programs										
9	Medical Director			13,950	13,950		13,950		13,950		9
10	Nursing and Medical Records	2,973,774	170,097	17,142	3,161,013		3,161,013	(411)	3,160,602		10
10a	Therapy	82,047		7,774	89,821		89,821		89,821		10a
11	Activities	128,271	13,887		142,158		142,158		142,158		11
12	Social Services	175,774	4,945	2,765	183,484		183,484		183,484		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*			530	530		530		530		15
16	TOTAL Health Care and Programs	3,359,866	188,929	42,161	3,590,956		3,590,956	(411)	3,590,545		16
	C. General Administration										
17	Administrative	75,533		1,267,963	1,343,496		1,343,496	(429,000)	914,496		17
18	Directors Fees										18
19	Professional Services			137,067	137,067	(4,168)	132,899	(29,629)	103,270		19
20	Dues, Fees, Subscriptions & Promotions			44,079	44,079		44,079	(24,333)	19,746		20
21	Clerical & General Office Expenses	149,304	25,077	214,277	388,658		388,658	(176,854)	211,804		21
22	Employee Benefits & Payroll Taxes			827,455	827,455	88,359	915,814	(10,766)	905,048		22
23	Inservice Training & Education			580	580		580		580		23
24	Travel and Seminar			8,837	8,837		8,837	(4,627)	4,210		24
25	Other Admin. Staff Transportation			6,094	6,094		6,094	(4,124)	1,970		25
26	Insurance-Prop.Liab.Malpractice			170,628	170,628		170,628		170,628		26
27	Other (specify):*							27,901	27,901		27
28	TOTAL General Administration	224,837	25,077	2,676,980	2,926,894	84,191	3,011,085	(651,432)	2,359,653		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,286,893	804,904	3,055,201	8,146,998	(4,168)	8,142,830	(716,693)	7,426,137		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			165,306	165,306		165,306	36,494	201,800			30
31	Amortization of Pre-Op. & Org.			15,515	15,515		15,515	(9,000)	6,515			31
32	Interest			379,222	379,222		379,222	(3,361)	375,861			32
33	Real Estate Taxes			322,946	322,946	4,168	327,114	(5,406)	321,708			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			4,180	4,180		4,180		4,180			35
36	Other (specify):*											36
37	TOTAL Ownership			887,169	887,169	4,168	891,337	18,727	910,064			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	44,142	77,617	28,347	150,106		150,106		150,106			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			149,468	149,468		149,468		149,468			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers	44,142	77,617	177,815	299,574		299,574		299,574			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	4,331,035	882,521	4,120,185	9,333,741		9,333,741	(697,966)	8,635,775			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	36,494	30		9
10	Interest and Other Investment Income	(3,361)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(31)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(2,107)	21		18
19	Entertainment	(4,627)	24		19
20	Contributions	(1,400)	20		20
21	Owner or Key-Man Insurance	(10,766)	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(163,904)	21		24
25	Fund Raising, Advertising and Promotional	(21,958)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(3,823)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(201,697)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (377,180)		\$	30

OHF USE ONLY							
48		49		50		51	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(320,786)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (320,786)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (697,966)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS		Page 5A
CLARK MANOR CONV CENTER		
ID#	0038596	
Report Period Beginning:	01/01/02	
Ending:	12/31/02	
		Sch. V Line
NON-ALLOWABLE EXPENSES		Reference
	Amount	
1	APARTMENT ELECTRIC	5
2	APARTMENT GAS	5
3	APARTMENT R&M	6
4	APARTMENT - FRED DAVIS	21
5	APARTMENT WATER	5
6	APARTMENT RE TAX	33
7	THEFT & DAMAGE LOSS	21
8	NON ALLOWABLE AUTO	25
9	IL COUNCIL LTC - COPE PAYMENTS	20
10	LOAN ORIGINATING COSTS	31
11	NON ALLOWABLE MGMT FEES	19
12	NON ALLOWABLE SALARY	17
13	NON ALLOWABLE PAYROLL TAX	27
14	MEDICAL RECORY COPY FEES	10
15	JURY DUTY - CNA	10
16	R&M CAPITALIZED	6
17	REAL ESTATE TAX REFUND	33
18	FRANCHISE TAX	21
19	APPRAISAL FEES	19
20	NON-ALLOWABLE LEGAL	19
21		21
22		22
23		23
24		24
25		25
26		26
27		27
28		28
29		29
30		30
31		31
32		32
33		33
34		34
35		35
36		36
37		37
38		38
39		39
40		40
41		41
42		42
43		43
44		44
45		45
46		46
47		47
48		48
49		49
50		50
51		51
52		52
53		53
54		54
55		55
56		56
57		57
58		58
59		59
60		60
61		61
62		62
63		63
64		64
65		65
66		66
67		67
68		68
69		69
70		70
71		71
72		72
73		73
74		74
75		75
76		76
77		77
78		78
79		79
80		80
81		81
82		82
83		83
84		84
85		85
86		86
87		87
88		88
89		89
90		90
91		91
92		92
93		93
94		94
95		95
96		96
97		97
98		98
99		99
100		100
101	Total	101

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED		NONE		J.S. AFFILIATES	CHICAGO, IL	MGMT COMP.
				SHAYMARK MGMT	LINCOLNWOOD, IL	MGMT COMP.
				JLR MGMT	LINCOLNWOOD, IL	MGMT COMP.

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☒ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	MANAGEMENT FEES	\$ 461,100	J.S. AFFILIATES		\$	\$ (461,100)	15
16	V	17	ADMIN ISTRATIVE FEES	486,900	J.S. AFFILIATES			(486,900)	16
17	V	17	ADMINISTRATIVE SALARY		J.S. AFFILIATES		878,800	878,800	17
18	V	27	PAYROLL TAXES		J.S. AFFILIATES		33,397	33,397	18
19	V	21	TELEPHONE		J.S. AFFILIATES		17	17	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 948,000			\$ 912,214	\$ * (35,786)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	Management Fees	\$ 105,000	Shaymark Management		\$	\$ (105,000)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 105,000			\$	\$ * (105,000)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	Management Fees	\$ 180,000	JLR Mgmt		\$	\$ (180,000)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 180,000			\$	\$ * (180,000)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	JACK SCHNELL	Executive Director	Administrative	10.94%	None	40	100.00%	Alloc. Sal	\$ 252,000	17-07	1
2	DAVID SCHNELL	Manager	Administrative	2.07%	None	40	100.00%	Alloc. Sal	288,000	17-07	2
3	MORRIS SCHABES	Manager	Administrative	1.32%	None	40	100.00%	Alloc. Sal	264,000	17-07	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 804,000		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CLARK MANOR CONV CENTER # 0038596 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number (____) _____
Fax Number (____) _____

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CLARK MANOR CONV CENTER # 0038596 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number (____) _____
Fax Number (____) _____

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CLARK MANOR CONV CENTER # 0038596 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

()

()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CLARK MANOR CONV CENTER # 0038596 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

()

()

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CLARK MANOR CONV CENTER # 0038596 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

()

()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CLARK MANOR CONV CENTER # 0038596 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

()

()

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.)

YES ☐

NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CLARK MANOR CONV CENTER # 0038596 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

()

()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CLARK MANOR CONV CENTER # 0038596 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

()

()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CLARK MANOR CONV CENTER # 0038596 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

()

()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CLARK MANOR CONV CENTER # 0038596 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

()

()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.	\$	0	Line #	n/a

* **Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.**
(See instructions.)

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)**

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	INTEREST INCOME		X				\$				\$ (3,361)	1
2	THE NATIONAL BANK		X	LINE OF CREDIT				171,604			4,644	2
3												3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							\$	171,604			\$ 1,283	21

B. Real Estate Taxes

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

CLARK MANOR CONV CENTER

COUNTY

COOK

FACILITY IDPH LICENSE NUMBER

0038596

CONTACT PERSON REGARDING THIS REPORT

Steve Lavenda

TELEPHONE

(847) 236-1111

FAX #:

(847) 236-1155

A.

Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A)	(B)	(C)	(D)
				<u>Tax</u>
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to Nursing Home</u>
1.	<u>11-30-411-020-0000</u>	<u>Long Term Care Property</u>	<u>\$ 1,066.04</u>	<u>\$ 1,066.04</u>
2.	<u>11-30-411-021-0000</u>	<u>Long Term Care Property</u>	<u>\$ 4,830.60</u>	<u>\$ 4,830.60</u>
3.	<u>11-30-411-005-0000</u>	<u>Long Term Care Property</u>	<u>\$ 115,482.92</u>	<u>\$ 115,482.92</u>
4.	<u>11-30-411-006-0000</u>	<u>Long Term Care Property</u>	<u>\$ 115,482.92</u>	<u>\$ 115,482.92</u>
5.	<u>11-30-411-007-0000</u>	<u>Long Term Care Property</u>	<u>\$ 99,583.94</u>	<u>\$ 99,583.94</u>
6.	<u></u>	<u></u>	<u>\$</u>	<u>\$</u>
7.	<u></u>	<u></u>	<u>\$</u>	<u>\$</u>
8.	<u></u>	<u></u>	<u>\$</u>	<u>\$</u>
9.	<u></u>	<u></u>	<u>\$</u>	<u>\$</u>
10.	<u></u>	<u></u>	<u>\$</u>	<u>\$</u>
		TOTALS	<u>\$ 336,446.42</u>	<u>\$ 336,446.42</u>

B.

Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home.
(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C.

Tax Bills

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

IMPORTANT NOTICE

TO:

Long Term Care Facilities with Real Estate Tax Rates

RE:

2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

CLARK MANOR CONV CENTER

COUNTY

COOK

FACILITY IDPH LICENSE NUMBER

0038596

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ()

FAX #: ()

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

(A)	(B)	(C)	(D)
			<u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to</u>
			<u>Nursing Home</u>
1.		\$	\$
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$	\$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home.
(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 49,255

B. General Construction Type: Exterior Frame Number of Stories 5

C. Does the Operating Entity? ☒ (a) Own the Facility ☐ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☒ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Apartment building: all expenses have been adjusted out on page 5

All costs are in the non care assets section of page 13

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☒ YES ☐ NO

If so, please complete the following:

1. Total Amount Incurred: 130,336

2. Number of Years Over Which it is Being Amortized: 20

3. Current Period Amortization: 6,515

4. Dates Incurred: 1990

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>facility</u>		<u>1977</u>	<u>\$ 220,000</u>	1
2					2
3	TOTALS			<u>\$ 220,000</u>	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	FOR OHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4				1977	\$ 3,129,625	\$ 104,319	35	\$ 104,321	\$ 2	\$ 1,999,484	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1977	50,000		20	-		33,889	9
10	Various			1984	35,709		20	1,785	1,785	24,397	10
11	Various			1985	25,843		20	1,292	1,292	14,212	11
12	Various			1986	40,628		20	2,031	2,031	21,265	12
13	Various			1987	11,439		20	572	572	5,148	13
14	Various			1988	14,754		20	738	738	6,642	14
15	Various			1989	16,022		20	801	801	7,209	15
16	Various			1990	18,810		20	940	940	8,460	16
17	Various			1991	2,950		20	147	147	1,323	17
18	Various			1992	70,740		20	3,538	3,538	31,842	18
19	Various			1993	15,908		20	795	795	7,155	19
20	Various			1994	41,939		20	2,095	2,095	17,438	20
21	Various			1995	60,407		20	3,020	3,020	22,764	21
22	Various			1996	91,646		20	4,583	4,583	29,773	22
23	Various			1997	163,698		20	8,188	8,188	45,447	23
24	Various			1998	133,227		20	6,665	6,665	31,420	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$ -	\$	\$ -	37
38						-		-	38
39						-		-	39
40						-		-	40
41						-		-	41
42						-		-	42
43						-		-	43
44						-		-	44
45						-		-	45
46						-		-	46
47						-		-	47
48						-		-	48
49						-		-	49
50						-		-	50
51						-		-	51
52						-		-	52
53						-		-	53
54						-		-	54
55						-		-	55
56						-		-	56
57						-		-	57
58						-		-	58
59						-		-	59
60						-		-	60
61						-		-	61
62						-		-	62
63						-		-	63
64						-		-	64
65						-		-	65
66						-		-	66
67						-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)								68
69	Financial Statement Depreciation			13,081			(13,081)		69
70	TOTAL (lines 4 thru 69)		\$ 3,923,345	\$ 117,400		\$ 141,511	\$ 24,111	\$ 2,307,868	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,923,345	\$ 117,400		\$ 141,511	\$ 24,111	\$ 2,307,868	1
2	COMPRESSOR	1999	1,015		20	51	51	204	2
3	REPAIR ROOF	1999	1,875		20	94	94	376	3
4	BEARING ASSEMBLY	1999	771		20	39	39	153	4
5	FAN COIL & INGNITER	1999	865		20	43	43	168	5
6	WINDOWS	1999	669		20	33	33	127	6
7	2 MOTORS & U BELTS	1999	854		20	43	43	161	7
8	SHEET METAL CONNECTO	1999	665		20	33	33	124	8
9	BEARING ASSEMBLY	1999	925		20	46	46	169	9
10	VALVE & ASSEMBLY	1999	2,402		20	120	120	430	10
11	2 MOTORS & SWITCHES	1999	537		20	27	27	92	11
12	PATIO DECK	1999	2,669		20	133	133	443	12
13	INSTALL DOOR MGNETS	1999	1,129		20	56	56	196	13
14	PIPE & SHEET METAL	1999	2,660		20	133	133	432	14
15	BEARING ASSEMBLY	1999	1,335		20	67	67	218	15
16	3 VALVES	1999	2,715		20	136	136	431	16
17	PUMP MOTOR	1999	750		20	38	38	120	17
18	PUMP BEARING ASSEM.	1999	810		20	41	41	130	18
19	MOTOR & BEARING ASSY	1999	765		20	38	38	117	19
20	HOT GAS DEFROST VALV	1999	785		20	39	39	120	20
21	2 DUAL DRIVE MOTOR	1999	1,188		20	59	59	182	21
22	PUMP	1999	8,245		20	412	412	1,614	22
23	BOOSTER HEATER	1999	2,393		20	120	120	240	23
24	GLOBAL RECONDITIONED	1999	979		20	49	49	98	24
25	SMOKE DET. CAMERA	1999	1,150		20	58	58	116	25
26	SMOKE DET. CAMERA	1999	350		20	18	18	36	26
27	TRANSFORMER	1999	1,350		20	68	68	136	27
28	COMPRESSOR	1999	9,132		20	457	457	914	28
29	SHEET METAL WORK	1999	5,533		20	277	277	1,062	29
30	ROOF MAINTENANCE	1999	2,450		20	123	123	410	30
31	SMOKE ALARM SYSTEM	1999	5,251		20	263	263	921	31
32	AIR-CONDITIONING	1999	12,989		20	649	649	2,217	32
33	PUMP	2000	1,846		20	92	92	276	33
34	TOTAL (lines 1 thru 33)		\$ 4,000,397	\$ 117,400		\$ 145,366	\$ 27,966	\$ 2,320,301	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 4,000,397	\$ 117,400		\$ 145,366	\$ 27,966	\$ 2,320,301	1
2	WALK-IN-COOLER	2000	7,000		20	350	350	992	2
3	INTERCOM	2000	1,142		20	57	57	147	3
4	STARTER & HEATER	2000	524		20	26	26	52	4
5	SECURITY DOOR PARTS	2000	1,855		20	93	93	186	5
6	KITCHEN FAN MOTOR	2000	3,358		20	168	168	336	6
7	MOTORFAN PULLEYS	2000	872		20	44	44	88	7
8	MOTOR & FAN	2000	640		20	32	32	64	8
9	VALVES	2000	2,745		20	137	137	274	9
10	TEMPERATURE CONTROLL	2000	935		20	47	47	94	10
11	FAN COIL MOTORS	2000	828		20	41	41	82	11
12	MOTORS & MOUNTS	2000	1,264		20	63	63	126	12
13	ROOM FAN COIL PARTS	2000	885		20	44	44	88	13
14	GAS GENERATOR & FANS	2000	640		20	32	32	64	14
15	WATER HEATER VALVE	2000	1,400		20	70	70	140	15
16	MOTOR	2000	1,074		20	54	54	108	16
17	THERMOSTAT	2000	541		20	27	27	54	17
18	HEATER VALVE	2000	1,865		20	93	93	186	18
19	BEARING ASSEMBLY	2000	1,709		20	85	85	170	19
20	3 FLANGED LUBE LOCKS	2000	3,785		20	189	189	378	20
21	MOTOR & REVERSES	2000	770		20	39	39	78	21
22	HEATING REP	2001	1,025		20	51	51	102	22
23	AIR CONDITIONER REPR	2001	3,540		20	177	177	310	23
24	HEATING REPAIR	2001	1,730		20	87	87	152	24
25	HEATING REPAIR	2001	1,775		20	89	89	148	25
26	INSULATION	2001	3,960		20	198	198	330	26
27	AIR HANDLER REPAIR	2001	1,890		20	95	95	158	27
28	RAILS & PLATES	2001	2,250		20	113	113	188	28
29	FAN REPAIR	2001	2,596		20	130	130	206	29
30	LOCKS	2001	1,833		20	92	92	138	30
31	LITCHEN SINK REP	2001	1,625		20	81	81	115	31
32	REBUILT PUMP	2001	910		20	46	46	61	32
33	AIR HANDLER REP	2001	2,335		20	117	117	146	33
34	TOTAL (lines 1 thru 33)		\$ 4,059,698	\$ 117,400		\$ 148,333	\$ 30,933	\$ 2,326,062	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 4,059,698	\$ 117,400		\$ 148,333	\$ 30,933	\$ 2,326,062	1
2	KITCHEN ELECTRICAL	2001	2,008		20	100	100	125	2
3	BOILER REPAIR	2001	2,236		20	112	112	140	3
4	PUMP REPAIR	2001	995		20	50	50	63	4
5	FIRE ALARM REP	2001	1,860		20	93	93	101	5
6	LOCK	2001	917		20	46	46	54	6
7	HEATING REP	2001	2,595		20	130	130	141	7
8	AIR HANDLER REP	2001	1,510		20	76	76	82	8
9	B&G PUMP	2001	720		20	36	36	39	9
10	TANK REPAIR	2001	1,761		20	88	88	95	10
11	AIR COND REPAIR	2001	2,236		20	112	112	177	11
12	SEWAGE PUMP	2001	7,447		20	372	372	589	12
13	BOILER REPAIR	2001	2,166		20	108	108	216	13
14	WINDOW SHADES	2001	1,439		20	72	72	120	14
15	CONVERTER PUMP	2001	725		20	36	36	48	15
16	THERMOSTATS	2001	1,206		20	60	60	95	16
17	TEMP SWITCHES	2001	1,350		20	68	68	102	17
18	FAN THERMOSTATS	2001	2,580		20	129	129	151	18
19	BOILER	2002	7,167		20	194	194	194	19
20	ELEVATOR OVERHAUL	2002	22,600		20	659	659	659	20
21	MINIBLINDS FOR PT ROOMS	2002	970		20	42	42	42	21
22	SHEET METAL CONTRACTOR	2002	1,425		20	62	62	62	22
23	NEW LIGHTS	2002	550		20	22	22	22	23
24	LINE TO NURSES CALL STATION	2002	1,134		20	45	45	45	24
25	WATER FEED VALVE	2002	825		20	33	33	33	25
26	LOCKSET SYSTEM	2002	553		20	22	22	22	26
27	CONTROLS & MOTOR	2002	1,585		20	56	56	56	27
28	3 WAY VALVE	2002	2,151		20	67	67	67	28
29	WALK IN COOLER REPAIR	2002	905		20	25	25	25	29
30	TUCKPOINTING	2002	850		20	23	23	23	30
31	INSULATION CONTRACTOR	2002	668		20	15	15	15	31
32	REBUILT PUMP	2002	653		20	15	15	15	32
33	FIRE ALARM REPAIR	2002	503		20	12	12	12	33
34	TOTAL (lines 1 thru 33)		\$ 4,135,988	\$ 117,400		\$ 151,313	\$ 33,913	\$ 2,329,692	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 4,135,988	\$ 117,400		\$ 151,313	\$ 33,913	\$ 2,329,692	1
2	FIRE ALARM REPAIR	2002	3,248		20	74	74	74	2
3	INSULATION CONTRACTOR	2002	3,197		20	47	47	47	3
4	FIRE PUMP REPAIRS	2002	564		20	4	4	4	4
5	INSULATION CONTRACTOR	2002	2,730		20	28	28	28	5
6	BOILER COIL	2002	1,975		20	21	21	21	6
7	PIPES & CONTRACTOR	2002	4,762		20	50	50	50	7
8	HONEYWELL CONTROL	2002	655		20	7	7	7	8
9	BOILER CONTROL	2002	620		20	4	4	4	9
10	RECHARGE REFRIDGERANT	2002	735		20	5	5	5	10
11	THERMOSTAT SWITCHES	2002	1,230		20	28	28	28	11
12	MOTORS & BEARINGS	2002	2,488		20	57	57	57	12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,158,192	\$ 117,400		\$ 151,638	\$ 34,238	\$ 2,330,017	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 4,158,192	\$ 117,400		\$ 151,638	\$ 34,238	\$ 2,330,017	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,158,192	\$ 117,400		\$ 151,638	\$ 34,238	\$ 2,330,017	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$4,158,192	\$117,400		\$151,638	\$34,238	\$2,330,017	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$4,158,192	\$117,400		\$151,638	\$34,238	\$2,330,017	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$ 4,158,192	\$ 117,400		\$ 151,638	\$ 34,238	\$ 2,330,017	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,158,192	\$ 117,400		\$ 151,638	\$ 34,238	\$ 2,330,017	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 4,158,192	\$ 117,400		\$ 151,638	\$ 34,238	\$ 2,330,017	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,158,192	\$ 117,400		\$ 151,638	\$ 34,238	\$ 2,330,017	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		\$ 4,158,192	\$ 117,400		\$ 151,638	\$ 34,238	\$ 2,330,017	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,158,192	\$ 117,400		\$ 151,638	\$ 34,238	\$ 2,330,017	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		\$4,158,192	\$117,400		\$151,638	\$34,238	\$2,330,017	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$4,158,192	\$117,400		\$151,638	\$34,238	\$2,330,017	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4					\$	\$		\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$	\$		\$	\$	\$	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$591,675	\$43,058	\$44,590	\$1,532	10	\$366,348	71
72	Current Year Purchases	39,197	3,071	3,795	724	10	3,795	72
73	Fully Depreciated Assets	339,998				10	339,998	73
74								74
75	TOTALS	\$970,870	\$46,129	\$48,385	\$2,256		\$710,141	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		1998 CADILLAC	1998	\$45,590	\$1,775	\$1,775		5	\$13,780	76
77										77
78										78
79										79
80	TOTALS			\$45,590	\$1,775	\$1,775			\$13,780	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$5,394,652	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$165,304	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$201,798	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$36,494	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$3,053,938	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	APARTMENT BUILDING - 1977	\$30,000	\$0	\$30,000	86
87	APARTMENT LAND - 1900	30,000	0	0	87
88					88
89					89
90					90
91	TOTALS	\$60,000	\$	\$30,000	91

G. Construction-in-Progress

	Description	Cost	
92			92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease

9. Option to Buy:
- ☐ YES☐ NO
- Terms:
- *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
- ☐ YES☐ NO
16. Rental Amount for movable equipment: \$ 4,180
- Description: copier: 2,839; fax machine: 853; postage meter: 464, carpet shampooer: 24
- (Attach a schedule detailing the breakdown of movable equipment)

10. Effective dates of current rental agreement:

Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	\$
13.	/2004	\$
14.	/2005	\$

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

* If there is an option to buy the building,
please provide complete details on attached
schedule.

** This amount plus any amortization of lease
expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER AIDE

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER AIDE

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.
- SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

1		2		3		4		5		6		7		8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)						
			Units of Service	Cost	Units	Cost									
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1					
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			3,979			3,979	2					
3	Licensed Recreational Therapist		hrs							3					
4	Licensed Physical Therapist	39 - 01	1532 hrs	44,142		24,368		1,532	68,510	4					
5	Physician Care		visits							5					
6	Dental Care		visits							6					
7	Work Related Program		hrs							7					
8	Habilitation		hrs							8					
9	Pharmacy	39 - 02	# of prescripts				61,240		61,240	9					
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs												
10	Academic Education		hrs							10					
11	Exceptional Care Program									11					
12										12					
13	Other (specify): See Supplemental						16,377		16,377	13					
14	TOTAL			\$ 44,142		\$ 28,347	\$ 77,617	1,532	\$ 150,106	14					

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 167,449	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,194,716		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	609		6
7	Other Prepaid Expenses	38,913		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Supplemental Schedule	312,426		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,714,113	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	250,000		13
14	Buildings, at Historical Cost	3,129,625		14
15	Leasehold Improvements, at Historical Cost	503,509		15
16	Equipment, at Historical Cost	1,338,913		16
17	Accumulated Depreciation (book methods)	(4,038,580)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	190,996		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(84,736)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Supplemental Schedule			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,289,727	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,003,840	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 362,986	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	117,597		28
29	Short-Term Notes Payable	1,477,968		29
30	Accrued Salaries Payable	107,025		30
31	Accrued Taxes Payable (excluding real estate taxes)	9,282		31
32	Accrued Real Estate Taxes(Sch.IX-B)	346,500		32
33	Accrued Interest Payable	42,796		33
34	Deferred Compensation			34
35	Federal and State Income Taxes	21,641		35
	Other Current Liabilities(specify):			
36	See Supplemental Schedule	73,701		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,559,496	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,583,699		39
40	Mortgage Payable	2,908,668		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Supplemental Schedule			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 4,492,367	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 7,051,863	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (3,048,023)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,003,840	\$	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,143,304)	1
2	Restatements (describe):		2
3	reclass of p/y distributions	327,840	3
4	p/y adjustment	(144)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (815,608)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	35,284	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Stockholder Buyout	(100,000)	15
16	Other (describe) Partner Buyout	(2,167,699)	16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (2,232,415)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (3,048,023)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 9,282,086	1
2	Discounts and Allowances for all Levels	(245,944)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,036,142	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	200,483	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 200,483	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	62,225	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	5,501	19
20	Radiology and X-Ray	2,744	20
21	Other Medical Services	16,024	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 86,494	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3,361	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3,361	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	42,545	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 42,545	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,369,025	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,629,148	31
32	Health Care	3,590,956	32
33	General Administration	2,926,894	33
	B. Capital Expense		
34	Ownership	887,169	34
	C. Ancillary Expense		
35	Special Cost Centers	150,106	35
36	Provider Participation Fee	149,468	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,333,741	40
41	Income before Income Taxes (line 30 minus line 40)**	35,284	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 35,284	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? not complete If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number CLARK MANOR CONV CENTER

0038596

Report Period Beginning:

01/01/02

Ending:

12/31/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,080	2,080	\$ 76,954	\$ 37.00	1
2	Assistant Director of Nursing	1,963	2,179	51,277	23.54	2
3	Registered Nurses	48,263	53,177	1,183,691	22.26	3
4	Licensed Practical Nurses	13,996	15,083	267,843	17.76	4
5	Nurse Aides & Orderlies	150,375	170,703	1,349,857	7.91	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	1,532	1,605	44,142	27.51	7
8	Rehab/Therapy Aides	7,354	8,412	82,047	9.75	8
9	Activity Director	1,624	1,752	25,856	14.76	9
10	Activity Assistants	12,165	13,220	102,415	7.75	10
11	Social Service Workers	10,974	11,807	175,774	14.89	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,240	41,410	18.49	13
14	Head Cook	6,223	6,947	62,688	9.02	14
15	Cook Helpers/Assistants	22,945	25,318	204,955	8.10	15
16	Dishwashers					16
17	Maintenance Workers	2,320	2,400	29,936	12.47	17
18	Housekeepers	27,861	30,857	252,717	8.19	18
19	Laundry	11,937	13,494	110,484	8.19	19
20	Administrator	2,080	2,137	75,533	35.35	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,093	10,737	149,304	13.91	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,605	3,741	44,152	11.80	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>					33
34	TOTAL (lines 1 - 33)	339,468	377,886	\$ 4,331,035 *	\$ 11.46	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	400	\$ 15,220	01-03	35
36	Medical Director	monthly	13,950	09-03	36
37	Medical Records Consultant	monthly	3,440	10-03	37
38	Nurse Consultant	221	5,518	10-03	38
39	Pharmacist Consultant	monthly	4,750	10-03	39
40	Physical Therapy Consultant	38	1,536	10a-03	40
41	Occupational Therapy Consultant	153	6,118	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	79	2,765	12-03	45
46	Other(specify)				46
47	<u>language rehab program</u>	3	120	10a-03	47
48	<u>kosher supervision</u>	monthly	3,648	01-03	48
49	TOTAL (lines 35 - 48)	894	\$ 57,065		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides	355	3,434	10-03	52
53	TOTAL (lines 50 - 52)	355	\$ 3,434		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount		Description	Amount
Mark Schlichting	Administrator	0	75,533	Workers' Compensation Insurance	\$	53,031	IDPH License Fee	\$ 400
				Unemployment Compensation Insurance		25,706	Advertising: Employee Recruitment	1,450
				FICA Taxes		327,943	Health Care Worker Background Check	510
				Employee Health Insurance		364,034	(Indicate # of checks performed 51)	
				Employee Meals		88,359	Dues	10,139
				Illinois Municipal Retirement Fund (IMRF)*			Advertising & Promotion	21,958
				Head Tax		8,168	subscriptions	1,114
				Disability Insurance		3,156	licenses	1,113
				Employee Retirement Plan		24,874	classified ads	5,020
				Christmas Expense		9,777		
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 75,533					
(List each licensed administrator separately.)								
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Management fees - see attached			\$ 769,200				Out-of-State Travel	\$
Administrative fees - see attached			498,763					
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 1,267,963					
(Attach a copy of any management service agreement)								
C. Professional Services								
Vendor/Payee	Type		Amount					
Frost, Ruttenberg & Rothblatt	Accounting		\$ 58,276					
Econocare	Purchasing Agent		3,590					
Personnel Planners	Unemployment Consult		1,400					
see attached	Computer Consulting		17,600					
see attached	Legal		40,100					
Transamerica Ins & Invest	401K Administration		5,601					
Real Estate Analysis Corp	Appraisal (not used for RE		7,500					
	tax appeal) (adj. Out on p5)							
Lorenz & Associates	Appraisal (not used for RE		3,000					
	tax appeal) (adj. Out on p5)							
TOTAL (agree to Schedule V, line 19, column 3)			\$ 137,067	TOTAL		\$		
(If total legal fees exceed \$2500 attach copy of invoices.)								

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	NONE		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number		CLARK MANOR CONV CENTER		STATE OF ILLINOIS				Page 23
		#	0038596	Report Period Beginning:	01/01/02	Ending:	12/31/02	

XX. GENERAL INFORMATION:

(1)

Are nursing employees (RN,LPN,NA) represented by a union?

YES

(2)

Are there any dues to nursing home associations included on the cost report?
If YES, give association name and amount.

IL Council on LTC: 11044

YES

(3)

Did the nursing home make political contributions or payments to a political action organization?

yes

If YES, have these costs been properly adjusted out of the cost report?

yes

(4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?

no

If YES, what is the capacity?

n/a

(5)

Have you properly capitalized all major repairs and equipment purchases?
What was the average life used for new equipment added during this period?

yes

10 yrs

(6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$

7,034

Line

10

(7)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

yes

If NO, attach a complete explanation.

(8)

Are you presently operating under a sale and leaseback arrangement?

no

If YES, give effective date of lease.

n/a

(9)

Are you presently operating under a sublease agreement?

YES

X

NO

(10)

Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?

YES

NO

X

If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period.

\$

149,468

This amount is to be recorded on line 42 of Schedule V.

(12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?

no

If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13)

Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?

yes

(14)

Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?

no

For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.

\$

88,359

Has any meal income been offset against related costs?

no

Indicate the amount.

\$

n/a

(16)

Travel and Transportation

a.

Are there costs included for out-of-state travel?

no

If YES, attach a complete explanation.

b.

Do you have a separate contract with the Department to provide medical transportation for residents?

no

If YES, please indicate the amount of income earned from such a program during this reporting period.

\$

n/a

c.

What percent of all travel expense relates to transportation of nurses and patients?

100% of ln

d.

Have vehicle usage logs been maintained?

no

e.

Are all vehicles stored at the nursing home during the night and all other times when not in use?

no

f.

Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

no

g.

Does the facility transport residents to and from day training?

no

Indicate the amount of income earned from providing such transportation during this reporting period.

\$

(17)

Has an audit been performed by an independent certified public accounting firm?

no

Firm Name:

The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached?

n/a

If no, please explain.

(18)

Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?

yes

(19)

If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report?

yes

Attach invoices and a summary of services for all architect and appraisal fees